Update in Guidelines for the Prevention and Control of Nosocomial Infections

Two portions of the CDC Guideline for Isolation Precautions in Hospitals are available in an updated version. The Guideline for Prevention of Surgical Wound Infections and the Guideline for Handwashing and Hospital Environmental Control have been revised. Copies of the guidelines may be purchased for $7.00 a copy from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
Telephone: (703) 487-4650

Malaria Prophylaxis for Travelers to Areas with Chloroquine-Resistant Plasmodium falciparum.*

New recommendations for malaria prophylaxis were published in response to evidence that weekly use of Fansidar was associated with fatal cutaneous reactions. The revised recommendations emphasized the weekly use of chloroquine or amodiaquine as the main chemoprophylaxis and suggested that the weekly prophylactic use of Fransidar be limited to travelers at very high risk of exposure to Chloroquine-resistant Plasmodium falciparum. They are long-term travelers to eastern and central Africa.

Short term (3 weeks or less) travelers to areas with Chloroquine-resistant P. falciparum should carry three adult dose tables of Fansidar. They should be taken when no medical care is available and a febrile illness occurs. The importance of personal protection from mosquito contact by use of insect repellants, insect sprays, nets and screens should be stressed.

The current recommendations are more complicated than before because they reflect an effort to balance the risks and benefits of prophylactic regimes for travelers. The CDC publication, "Health Information for International Travel," 1985 can be used as a reference or one can obtain assistance by calling the Communicable Disease Program, Montana Department of Health and Environmental Sciences at (406) 444-4740.

*Excerpted from MMWR, January 17, 1986.

JG/war-051b

Adult Td (Tetanus-diphtheria) vaccine

Currently the State Immunization Program has exhausted supplies of Adult Td vaccine (even after borrowing 400 doses from another state's supply). The manufacturer has had this vaccine on backorder since September due to a long wait for FDA approval of their new plant, which was rebuilt after a major fire.

The latest information we have is that they will begin supplying their backorders in mid-March 1986. Sorry for the inconvenience of the break in stock.

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Volume: 10: 1 Month of: JANUARY 1986

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620.
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JANUARY 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead											1				
Big Horn			2	5		1									
Blaine			1												
Broadwater															
Carbon				2											
Carter												3			
Cascade	4			10	1	8	4								
Chouteau															
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Daniels															
Dawson	1		1									4			
Deer Lodge															
Fallon											4	5			
Fergus														1	
Flathead	2		1	4			3		1		1		2		
Gallatin		3		2	1	1									
Garfield												1			
Glacier		1	1	4		1									
Golden Valley															
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Hill		3											1		
Jefferson		1													
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Lake		2		3											
Lewis & Clark		1		1			1			1					
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Petroleum															
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Pondera												1	1		
Powder River												5			
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Richland												1			
Roosevelt			4	4		1						4	3	2	
Rosebud				4											
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Silver Bow	1														
Stillwater							1								
Sweet Grass				1											
Teton															
Toole												2			
Treasure															
Valley												1			
Wheatland															
Wibaux												2			
Yellowstone		10	1	16			2	1	2						1
MONTHLY TOTAL 19 86	8	22	11	61	2	12	11	1	3	2	16	34	7	3	1
MONTHLY TOTAL 19 85	3	6	8	53	1	11	2	1	1	2	28	11	12	7	2
MONTHLY TOTAL 19 84	2	-	8	93	2	5	3	0	0	0	1	5	4	2	1
TOTAL TO DATE 19 86	8	22	11	61	2	12	11	1	3	2	16	34	7	3	1
TOTAL TO DATE 19 85	3	6	8	53	1	5	3	1	1	2	28	11	12	7	2
TOTAL TO DATE 19 84	2	-	8	93	2	1	3	0	0	0	1	5	4	2	1

OTHER DISEASES: Influenza: Sporadic to regional-Types A & B.
Mumps: Yellowstone, 1.

DELAYED REPORTS:

DAY CARE CENTER INFECTION CONTROL*

The steady increase in the number of children spending time in day care has led to a growing awareness of the potential for transmission of infectious agents in day care centers (DCC). Public health authorities, physicians, and health care providers will be called on with increasing frequency for guidance in prevention and control of infectious disease in this unique epidemiologic setting.

In May 1983, the Conference of State and Territorial Epidemiologists requested that the Centers for Disease Control (CDC) analyze the performance of DCC workers and, if needed, develop appropriate training materials. As a result, a 4-booklet training kit, "Stop Disease in Child Day Care Centers," was designed. The CDC training booklets addressed to DCC directors and caregivers ensure that all directors and caregivers are provided with knowledge to prevent and control disease transmission in the DCC environment. Every licensed day care in Montana is receiving a training kit.

The booklet addressed to parents stresses how parents can work with their DCC to keep children healthy and to minimize their child's disease risk. Some disease symptoms may endanger the child's health, as well as the health of other center children and staff if the ill child remains at the center. Parents are advised of the importance of being prepared for these unavoidable sick days by making alternate child care arrangements in advance to avoid changes in plans and expectations.

Children's physicians should be aware that the booklets cover immunization requirements, and rules for handling and excluding ill children.

The booklet entitled "What You Can Do To Stop Disease In Your Child's Day Care Center -- A Handbook for Parents," recommends that children stay at home if any of the following develop: (1) diarrhea, (2) severe coughing (child gets red or blue in the face, or makes high-pitched croupy or whooping sound after he coughs), (3) difficult or rapid breathing (this is especially important in an infant under 6 months old), (4) yellowish skin or eyes and (5) pinkeye (tears, redness of eyelid lining, irritation followed by swelling and discharge of pus). The ill child should stay at home until symptoms disappear or the attending physician decides that the child can return to the center without danger to himself or to the other children and staff.

Parents are also instructed to keep children home if they develop a fever (100° F. or above by oral thermometer or 101° F. or above by rectal thermometer) accompanied by any of the following: (1) unusual spots or rashes, (2) sore throat or trouble swallowing, (3) infected skin patches (crusty, bright yellow, dry or gummy areas of skin), (4) unusually dark, tea colored urine, (5) grey or white stool, (6) headache and stiff neck, (7) vomiting, (8) unusual behavior (child is cranky or less active than usual, child cries more than usual, child feels general discomfort or just seems unwell), (9) loss of appetite, (10) severe itching of body or scalp or stratching of scalp. As mentioned in the previous paragraph, the child may return to the center when symptoms disappear or the physician approves.

The length of exclusion for certain contagious diseases is indicated by the following table taken directly from the parents handbook.

Disease	When a Child Can Safely Return to the Center
Bacterial meningitis	When the Health Department indicates it is safe
Chicken pox	One week after the rash begins, or when all chicken pox are scabbed over
Diarrhea	When he no longer has diarrhea
If you know it is any of the following diseases: Shigella, Campylobacter, Salmonella, Giardia	When your physician or the Health Department says it is safe
Diphtheria	When your physician tells you it is safe
Hepatitis A	1 week after the illness begins
Measles	5 days after the rash appears
Mumps	After swelling subsides (or 9 days after swelling begins)
Pertussis (Whooping cough)	4 weeks after intense coughing begins, or 5 days after antibiotic treatment begins
Pneumonia	If not due to H-flu, when your physician says it is safe
or epiglottitis	If due to H-flu, when the Health Department indicates it is safe
or infectious acute arthritis	
Rubella (German measles)	5 days after the rash appears

*Reprinted from Utah Communicable Disease Newsletter, January, 1986.

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MONTANA MORBIDITY REPORT

Volume: 10: 2 **Month of:** FEBRUARY 1986

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Beaverhead				2											
Big Horn															
Blaine			1												
Broadwater															
Carbon															
Carter											1	4			
Cascade		4	1	5		1									
Chouteau															
Custer		1		1							3	1			
Daniels															
Dawson		1								1	1		1		
Deer Lodge															
Fallon															
Fergus															
Flathead			1	2						1					
Gallatin		5													
Garfield												1			
Glacier			1												
Golden Valley															
Granite															
Hill		5		3							1				
Jefferson															
Judith Basin															
Lake				1	1	1	2								
Lewis & Clark			1	2									1		
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Roosevelt				4		1						1	2	1	
Rosebud				2								1			
Sanders															
Sheridan												1			
Silver Bow										1					1
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Wibaux												1			
Yellowstone		18		13		1	1								
MONTHLY TOTAL 19 86	3	35	5	44	2	4	3	0	0	3	6	15	5	1	1
19 85	8	11	12	63	1	9	3	1	2	1	27	21	5	7	5
19 84	1	-	2	81	1	6	4	2	0	1	6	7	4	0	1
TOTAL TO DATE 19 86	12*	57	16	105	4	14*	5*	1	3	4*	22	42	12	4	2
19 85	11	17	24	116	2	20	5	2	3	3	55	31	7	14	7
19 84	3	-	10	174	2	11	7	2	0	1	7	12	8	0	2

OTHER DISEASES: Mumps: Lewis & Clark,1; Yellowstone,1. Chickenpox: Dawson,28; Flathead,8; Gallatin,2; Missoula,4; Yellowstone,2. Bact. meninoitis, unspec.: Lincoln,1; Yellowstone,1. Strep pneumococcal meningitis: Flathead,1. Early latent syphilis 1 yr.: Silver Bow,1. Primary syphilis: Yellowstone,1.

DELAYED REPORTS: Amebiasis: 1, Missoula (January); Animal rabies: delete 7 cases from January.

NOTE: '*' denotes changes in initial January counts.

DICK PAULSEN SELECTED TO BE PROGRAM MANAGER

Dick Paulsen is now the Program Manager for the Immunization and Sexually Transmitted Disease programs. Mr. Paulsen has worked for MSOHES for 12 years in the laboratory and as a Field Health Officer. He can be contacted at the Cogswell Building and his phone number is now (406) 444-3629.

RECOMMENDATIONS FOR PREVENTING HIB DISEASE*

The primary strategy for preventing Hib disease is immunization. Children should be vaccinated at 24 months of age. Those at high risk for Hib disease, including children attending day-care, may be given the vaccine at 18 months of age. ACIP guidelines for use of the vaccine should be consulted. (1). This update addresses chemoprophylaxis (recommendations 1-7) and additional vaccine issues (recommendations 8 and 9).

Chemoprophylaxis. Although unexplained disparities in available data prevent a precise estimate of the magnitude of risk among day-care contacts, it is likely that the increased risk of disease observed among young household contacts is also present among day-care classroom contacts under 2 years of age. Since rifampin prophylaxis is effective in preventing subsequent cases in this high-risk group, the ACIP recommends that:

1. Contacts of all ages who develop symptoms suggestive of invasive Hib disease, such as fever or headache, be evaluated promptly by a physician.

2. In any household in which a case of invasive Hib disease has occurred and in which another child under 4 years of age resides, all members of the household, including adults, should receive rifampin according to the following regimen: rifampin in a dosage of 20 mg/kg per dose once daily (maximal daily dose 600 mg) for 4 days; the dose for neonates (under 1 month of age) is 10 mg/kg once daily for 4 days.

3. In day-care classrooms in which a case of Hib disease has occurred and in which another child under 2 years of age has been exposed, all parents should be notified (preferably in writing) regarding the occurrence of the case and the possibility of increased risk to their children. They should be informed about the symptoms and the need for prompt medical evaluation if symptoms occur. They should also be notified of the availability of rifampin prophylaxis. Although the data on which to base recommendations are not optimal, and some authorities disagree, the consensus of the ACIP is as follows: In a day-care classroom in which a case of systemic Hib disease has occurred, and in which one or more children under 2 years old have been exposed, strong consideration should be given to administering rifampin prophylaxis to all children and staff in the classroom, regardless of age.

4. Rifampin should not be used in pregnant women, as its effect on the fetus has not been established, and it is teratogenic in laboratory animals.

5. Chemoprophylaxis should be instituted as rapidly as possible. If more than 14 days have passed since the last contact with the index patient, the benefit of chemoprophylaxis is likely to be decreased.

6. All children convalescing from systemic Hib disease who are anticipated to resume close contact with other young children, at home or in day-care, should receive rifampin immediately after completing treatment for their illness. Therapy for systemic disease does not reliably eradicate respiratory carriage of Hib, and some physicians may wish to give rifampin to all index patients.

7. In day-care classrooms in which children are to receive chemoprophylaxis, children who have received the Haemophilus b polysaccharide vaccine should also receive rifampin. Although these children are felt to be at decreased risk for disease, the vaccine probably does not affect carriage of the organism, which they may pass on to susceptible classmates.

8. Children who have had invasive Hib disease when they were under 24 months of age should still receive the vaccine according to previous recommendations, since most children under 24 months of age fail to mount an immune response to the clinical disease.

9. Satisfactory response to the vaccine is not consistent among children 18-23 months of age, and most authorities believe that these children should be revaccinated. Although data on the precise timing of this second dose are not currently available, it would be reasonable to reimmunize 2-12 months after the initial dose but not before 24 months of age. Previous immunization does not change the immune response or adverse reaction to a subsequent dose of the vaccine (21).

*MMWR, March 21, 1986

ATTENTION: Public vaccine providers RE: Return of vaccine shipment containers

The business reply envelopes attached to vaccine shipment receipt forms are to be used only to return the yellow copy of said form to this office. Postage for return of shipment containers became the responsibility of your offices, when we began paying for vaccine delivery postage.

Some providers have attached them to our shipping containers for return to us. That is ILLEGAL and the postal service reserves the right to destroy those containers. Business reply envelopes are for "letter" mail only! Some offices have paid the postage on the package on their end, used our business reply envelopes as an address label only, and we have been charged postage again on this end. This makes our office very unhappy!!

PLEASE, PLEASE, PLEASE do not use our business reply envelopes to return your containers, whether or not you pay postage on your end.

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Volume: 10: 3 Month of: MARCH 1986

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Beaverhead															
Big Horn				2											
Blaine				1											
Broadwater															
Carbon															
Carter															
Cascade		1	2	9		1					2				
Chouteau															
Custer											5	1			
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Dawson		1										3	1		
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Fergus												2			
Flathead	1			1	1										
Gallatin		17	1	6							1				
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Glacier				5											
Golden Valley															
Granite				2											
Hill		2		2							1				
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Powder River												1			
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Richland												1			
Roosevelt				2									1	3	
Rosebud				1	1										
Sanders															
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Silver Bow			1	1											
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Wheatland															
Wibaux															
Yellowstone		10		18	2		1	1							
MONTHLY TOTAL 19 86	1	37	6	63	4	2	1	1	1	0	10	13	3	3	3
MONTHLY TOTAL 19 85	3	4	8	67	1	1	4	0	1	0	25	14	10	3	11
MONTHLY TOTAL 19 84	3	-	16	84	3	4	2	0	0	0	3	3	6	1	5
TOTAL TO DATE 19 86	13	94	22	168	8	16	10	2	2	4	32	62	15	7	5
TOTAL TO DATE 19 85	14	21	32	183	3	21	9	2	4	1	80	46	27	17	18
TOTAL TO DATE 19 84	6	-	18	258	3	13	9	2	0	1	10	15	14	3	7

OTHER DISEASES: Chickenpox: 90 cases. Toxic Shock Syndrome: Silver Bow, 1. Mononucleosis: 27 cases. Post-"other" encephalitis: Lincoln, 1.

DELAYED REPORTS:

TB TESTING REQUIRED FOR SCHOOL EMPLOYEES

The Administrative Rules of Montana related to Communicable Disease Control require employees of schools and day care facilities to have tuberculin testing before or within 30 days of commencement of employment.(1) Ideally, any person employed in public or private K-12 institutions or day cares will have a tuberculin skin test result noted in his/her employee file. If the person is a known tuberculin reactor the ARM spells out the method by which this requirement can be satisfactorily met.

The value in such a rule is having recordation of baseline t.b. infection information should a case or infection occur in the day care or school. If contact testing is required at some time, comparison of the results to baseline data will allow discovery of definite conversions. People who have definite conversions of skin test status from negative to positive are at the highest risk of becoming cases of tuberculosis disease in the next two years.

Another reason for the testing requirement is to monitor the rate of tuberculosis infection in a community. Testing of school children is not required unless the overall community rate of infection is greater than 1%. The need for mass community screening tests is not warranted so monitoring groups at high risk of infection (health care workers) and persons who could infect children can be one method of monitoring the community incidence of t.b. infection.

(1) Administrative Rules of Montana, 16.28.1005, p. 16-1248, September 30, 1981.

SEXUALLY TRANSMITTED DISEASE TREATMENT GUIDELINES AND CHLAMYDIA TRACHOMATIS INFECTION POLICY GUIDELINES

The above named guidelines are now available from the Nursing Bureau, DHES. The 1985 STD Treatment Guidelines are an update of the former edition from United States Department of Health and Human Services. The document is the same as material printed in the Morbidity and Mortality Weekly Report Supplement, Volume 34, Number 45, October 18, 1985. Diseases covered in the guidelines include the following:

- Acquired Immunodeficiency Syndrome
- Chancroid
- Chlamydia trachomatis
- Enteric Infections
- Gonococcal Infections
- Hepatitis
- Genital Herpes
- Lymphogranuloma Venereum
- Nongonococcal Urethritis
- Parisitic Skin Infections
- Acute Pelvic Inflammatory Disease
- Syphilis
- Trichomoniasis
- Genital and Aoal Warts
- Other Genito-Urinary Syndromes
- Prevention of Special and Neonatal Infections
- Special Treatment-Related Discussion
- Public Health Considerations

The Chlamydia trachomatis Infections Policy Guidelines for Prevention and Control are also from DHHS. They were first published in August, 1985. Issues discussed in this manual are as follows:

- Background
- Patient management
- Prevention and surveillance

Either one or both of the booklets are available free of charge by calling the Nursing Bureau, Sexually Transmitted Disease Program at 444-4740 or writing to the above bureau and program at the Cogswell Building, Helena, Montana 59620.

JUNE 5 & 6, 1986 — ANNUAL MEETING - MONTANA STATEWIDE FAMILY PLANNING COUNCIL — BILLINGS

The Montana Statewide Family Planning Council's Annual Meeting, "RENEWING THE COMMITMENT", will be held at the Northern Hotel in Billings on June 5 and 6, 1986. Al Moran, Executive Director of Planned Parenthood of New York City, will be the keynote speaker on June 5th. Mr. Moran is an authority in the field of family planning and reproductive health care and is active in public affairs and advocacy. He is a former board member of the Alan Guttmacher Institute and the National Family Planning and Reproductive Health Association (NFPRHA), as well as a recipient of the Planned Parenthood Federation of America's Margaret Sanner Award. Bruce Vorhauer, Ph.D., Chairman of the Board and founder of VLI Corporation, will present a special session on June 6th, "The Contraceptive Sponge -- Development and Current Research." Dr. Vorhauer will have just returned from the World Congress of Sexually Transmitted Diseases.

Educational sessions will be presented on medical records and adequate legal documentation; presenting community educational workshops; maximizing patient collections; dealing with adolescent clients; clinical concerns; and front desk strategies. The registration fee is $10.00 for Title X agencies and $25.00 for all others. Pre-registration is required. For further information contact: Colleen Lindsay, Family Planning Program, Department of Health & Environmental Sciences, Cogswell Building, Helena, MT 59620, telephone (406) 444-4740.

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Volume: 10: 5 Month of: APRIL 1986

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Beaverhead				2											
Big Horn				4											
Blaine				1					1			1			
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Carbon				1											
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Cascade		5		6		2	1								
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Wibaux												5			
Yellowstone		23	1	9			2		1						
MONTHLY TOTAL 1986	5	62	15	63	6	8	6	1	4	1	7	41	3	2	2
MONTHLY TOTAL 1985	5	14	18	56	2	14	2	1	1	1	7	23	9	1	3
MONTHLY TOTAL 1984	2	-	8	91	1	8	0	1	1	0	2	22	6	2	2
TOTAL TO DATE 1986	18	156	37	231	14	24	16	3	6	5	20	103	18	9	7
TOTAL TO DATE 1985	19	35	50	239	5	35	11	3	5	3	27	67	36	19	21
TOTAL TO DATE 1984	8	-	26	349	4	21	9	3	1	1	13	37	20	5	10

APRIL REPORTS, OTHER: Bacterial meningitis, unspecified: Yellowstone, 1.
Meningococcal infection, civilian: Richland, 1.
Mumps: Lake, 1.
Strep pneumococcal meningitis: Big Horn, 1.

DELAYED REPORTS:

JANUARY: AIDS: Gallatin, 1.
Bacterial meningitis, unspec.: Carbon, 1.
Toxic Shock Syndrome: Lewis & Clark, 1

FEBRUARY: Measles, imported: Lewis & Clark, 1.

MARCH: AIDS: Cascade, 1.
Amebiasis: Missoula, 1.
Aseptic meningitis: Cascade, 1.
Colorado Tick Fever: Missoula, 1.
H. flu epiglottis: Flathead, 1.
Pertussis: Custer, 1.

MAY 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		1		3							1				
Blaine		5													
Broadwater															
Carbon															
Carter												1			
Cascade		1		4		2						1			1
Chouteau													1		
Custer				2								1			
Daniels															
Dawson				1								2			
Deer Lodge															
Fallon												1			
Fergus												5			
Flathead		1		2			1								
Gallatin	1	15	2	2	1										
Garfield															
Glacier			1	6											
Golden Valley															
Granite															
Hill		18	1	1	1						1				
Jefferson															
Judith Basin															
Lake		1	2	2	1										
Lewis & Clark	1	2	1	1							3				
Liberty									1						
Lincoln							1								
McCone											1	1			
Madison															
Meagher															
Mineral															
Missoula		16		3						1					
Musselshell															
Park				1											
Petroleum															
Phillips		2										1			
Pondera			1								1	3			
Powder River												2			
Powell															
Prairie															
Ravalli															
Richland															
Roosevelt				7									1		
Rosebud				5							2				
Sanders				1											
Sheridan												2			
Silver Bow		3		1							1				
Stillwater				1											
Sweet Grass															
Teton															
Toole												1			
Treasure															
Valley				1								1			
Wheatland															
Wibaux												1			
Yellowstone		16		15			2			1	1		1		
MONTHLY TOTAL 1986	2	81	8	59	3	2	4	0	1	1	11	23	3	0	1
MONTHLY TOTAL 1985	3	15	8	49	3	9	1	0	0	0	3	29	11	1	9
MONTHLY TOTAL 1984	4	5	7	92	0	21	0	0	0	0	14	11	3	0	2
TOTAL TO DATE 1986	20	237	45	290	17	26	20	2	7	7	50	126	21	9	8
TOTAL TO DATE 1985	22	50	58	288	8	44	12	3	5	4	90	98	47	19	30
TOTAL TO DATE 1984	12	19	33	441	4	42	9	3	1	1	27	48	23	5	12

OTHER DISEASES: Chickenpox: 33; Colorado tick fever: Msla,1; Bact. meningitis,other: Ylwstn,1; Mumps: Lake,2; Ornithosis: L & C,1; Pertussis: Ylwstn,1; Rocky Mtn Spotted fever Msla,1, Ravalli,1. Measles, indig.: Flthd,1. Typhoid fever Flthd,1. Syphilis: early latent< 1 year: Hill,1, primary: Cascade,1.

DELAYED REPORTS: Pertussis: late April reports: Flathead, 1; Jefferson, 1; Valley, 1.

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Volume: 10: 6 Month of: MAY 1986

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Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

Escherichia coli (E. coli) O157:H7 - Related Illnesses in the Western States*

In April of this year, six children from the Spokane, Washington area developed Hemolytic Uremic Syndrome (HUS). The organism implicated in this outbreak was E. coli O157:H7, and the suspected vehicle was hamburger ingested during the week prior to the onset of illness.

We lack clear knowledge of the mode of transmission and the likely reservoir of this organism for cases of HUS and hemorrhagic colitis. We are interested in conducting a brief cross-sectional survey for cases of hemorrhagic colitis/hemolytic uremic syndrome associated with E. coli O157:H7 that occur in the western states. We would appreciate your help in locating human cases of hemorrhagic colitis and HUS related to E. coli O157:H7. Timely knowledge of such isolated, sporadic, or epidemic cases would allow prompt contact with the patients, and generation of information concerning potential risk factors for the diseases.

HUS has been a difficult disease to characterize and many organisms and etiologies have been implicated. However, from previous outbreaks several points have emerged:

1) HUS related to E. coli O157:H7 may be endemic in western states.
2) E. coli O157:H7-related HUS in infants frequently has a prodromal hemorrhagic diarrhea prior to onset of uremic signs, although this is not an invariable characteristic.
3) E. coli O157:H7 has been isolated from cases of hemorrhagic colitis without progression to HUS.
4) Ingestion of rare or raw hamburger within the week prior to onset of clinical signs of hemorrhagic colitis/diarrhea has been associated with the outbreaks, as has the ingestion of raw milk.
5) Although E. coli O157:H7 has been isolated from portions of implicated hamburger, it has yet to be isolated from cattle.

The plan for monitoring this problem includes the following:

1) Follow-up of sporadic and epidemic E. coli O157:H7 related to cases of hemorrhagic colitis and HUS. This would entail receiving reports of such cases promptly from each state epidemiologist, or from the state public health laboratory.
2) Surveillance of routine isolates of E. coli from cattle in the western states. This would require State Veterinary Diagnostic Laboratories to send us random fecal E. coli isolates for typing. The rationale behind this animal surveillance is that beef in the form of hamburger has frequently been associated with outbreaks of HUS and hemorrhagic colitis due to E. coli O157:H7. Yet these diseases are not reconnized entities among cattle, nor has this organism been isolated from cattle. It is not clear whether the organism is present in cattle and has gone unrecognized. Surveillance of random cultures of E. coli from the State Veterinary Diagnostic Laboratories may reveal the presence of the organism in the cattle population in the west.

Montana has agreed to cooperate with Centers for Disease Control (CDC) in studying this problem. If you are aware of recent past cases of these two disease states, or upon suspecting that a person will be a case, please call Judith Gedrose, R.N., M.N., State Epidemiologist, at 444-4740. The DHES Microbiology Laboratory needs a specimen of the bloody stool to do appropriate testing -- please do not send isolates unless they have been picked from the selective media specifically designed for the isolation of these serotypes.

* From Centers for Disease Control, June 6, 1986

-- MEASLES --

1. FLATHEAD COUNTY - Six (6) cases of 7-day, hard measles were recently reported. The initial case, a 21-month-old unimmunized child, who broke out in a rash on May 6, probably contracted the disease while visiting in southern California in mid-April. The five other cases of measles, resulting from exposure to the first case, occurred in preschoolers who were not immunized at the time of exposure. The last confirmed case had a rash onset of May 22. There have been several other rash illnesses reported in the area.
2. CASCADE COUNTY - A 12-year-old from Kalispell broke out in a rash on June 2, while staying with her grandmother in Great Falls. The child had been immunized for measles after her first birthday, but prior to 15 months of age. The case has been linked epidemiologically with other Kalispell cases. Potential exposure to several children in the Great Falls area may have occurred. The case has been laboratory confirmed.
3. CANADA - In the Vancouver, British Columbia area, the site of Expo '86, there have been over 5,900 measles cases reported this year. Travellers to areas experiencing measles outbreaks should be sure of their immunization status. Persons born before 1957 are considered immune. Persons between 15 months and 29 years of age should have received a live measles vaccine since their first birthday and, if not certain about their measles status, immunization should take place before departure.

   The age of vaccination should be lowered for those children travelling to areas where measles is endemic or epidemic. Children 12-14 months of age may receive MMR before their departure, without need for revaccination. Children 6-11 months of age should receive a dose of single measles antigen vaccine (without rubella or mumps antigens) before departure and must be revaccinated with MMR vaccine. While the optimal age at revaccination is 15 months, the age at revaccination may be as low as 12 months if the child remains in a high-risk area. In this situation, further doses of measles vaccine are not indicated. Since virtually all infants less than 6 months of age will be protected by maternally-derived antibodies, no additional means to provide protection against measles is generally necessary.

SYPHILIS IS ON THE RISE IN MONTANA

More cases of infectious syphilis have been reported in the first 6 months of this year than were reported in all of 1985. During the same period last year, Montana had only 2 cases compared to a total of 9 now being reported in Cascade, Glacier, Hill, Roosevelt, Silver Bow, and Yellowstone counties. This outbreak has resulted in extensive investigative activities, with over 40 contacts being located and examined.

Symptoms associated with infectious syphilis may last only a short period of time, and include painless sores or blisters, usually in the genital area, a body rash, and/or swollen glands in the groin area.

Those who should have blood tests done:

1. Any patient with the following symptoms:
   a) rash;
   b) genital and/or oral lesions, sores, blisters, or a history of these;
   c) unexplained adenopahty, specifically inguinal;
   d) unexplained fever, night sweats, or fatigue;
   e) sexual exposure to a person with the above symptoms;
2. Gay or bisexual males;
3. Patients with multiple partners;
4. History of or exposure to any sexually transmitted disease;
5. No serology in past year and sexually active with multiple partners; and/or
6. Any pregnant female.

RECOMMENDED TREATMENT

Early syphilis (primary, secondary, early latent):
- ☐ 2.4 mu Benzathine Pen. G (IM)
- ☐ 30 gm Tetracycline 0.5 gm QID x 15 days (oral)
- ☐ 30 gm Erythromycin 0.5 gm QID x 15 days (oral)

Syphilis of more than one year's duration:
- ☐ 7.2 - 9.0 mu Benzathine Pen. G (latent or late syphilis) 2.4 mu at 1 wk intervals (IM)
- ☐ 60 gm Tetracycline 0.5 gm QID x 30 days (oral)
- ☐ 60 gm Erythromycin 0.5 gm QID x 30 days (oral)

VDRL and FTA-ABS testing is readily available to health care providers throughout the state for a lab slip fee of $1.75. The tests are run through the state microbiology laboratory. Suspected or confirmed cases should be reported to your local health department or by calling Dick Paulsen, Program Manager at 444-4740.

Haemophilus b Polysaccharide Vaccine

For those who are planning to order the new Haemophilus b polysaccharide vaccine in the 10-dose vial--REMEMBER--once reconstituted the vial needs to be used within 30 days. This may cause a problem for those in rural medical settings whose patient volume is low. You may wish to coordinate your ordering and usage of the vaccine with other low-volume users in your area.

FREE Tuberculin Purified Protein Derivative (PPD) on request

The Tuberculosis Program has twelve 10-test vials of PPD that will outdate on August 13, 1986. Those clinics that would be interested in using this supply should contact the Program office at 444-4740...as soon as possible.

JUNE 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead											1				
Big Horn		1		1											
Blaine				1											
Broadwater															
Carbon															
Carter															
Cascade	1	6		6			2								
Chouteau															
Custer											1	1			
Daniels											1				
Dawson											2	1			
Deer Lodge		1													
Fallon												2			
Fergus												5			1
Flathead		1		1											
Gallatin	4	10	6	8							1				
Garfield															
Glacier	1		2	5			1								
Golden Valley															
Granite															
Hill		13	1	2			1								
Jefferson															
Judith Basin															
Lake			3		1										
Lewis & Clark		2		6		1		1							
Liberty															
Lincoln				2											
McCone												1			
Madison															
Meagher															
Mineral															
Missoula	1	3		1							2				
Musselshell															
Park	1														
Petroleum															
Phillips															
Pondera	1											1			
Powder River											1				
Powell		1	1												
Prairie									1						
Ravalli				1											
Richland															
Roosevelt			2	13	1										
Rosebud				2											
Sanders															
Sheridan												2			
Silver Bow		3		2			1								1
Stillwater	1														
Sweet Grass															
Teton															
Toole															
Treasure															
Valley												1			1
Wheatland															
Wibaux												1			
Yellowstone	2	14	1	13			1	1			1			1	
MONTHLY TOTAL 19 86	12	55	16	64	2	1	6	2	1	0	10	15	0	1	3
MONTHLY TOTAL 19 85	5	8	15	51	1	5	2	0	1	0	8	12	3	3	1
MONTHLY TOTAL 19 84	11	4	12	65	2	14	1	0	0	0	3	12	9	1	2
TOTAL TO DATE 19 86	31	292	61	354	18	28	25	4	7	7	59	141	21	10	11
TOTAL TO DATE 19 85	27	58	73	339	9	49	14	3	6	4	98	110	50	22	31
TOTAL TO DATE 19 84	23	23	45	506	6	56	10	3	1	1	30	60	32	6	14

OTHER DISEASES: Chickenpox: 18. AIDS: Missoula,1. Viral meningitis: Lewis & Clark,1. Bact. meningitis, unspec: Lewis & Clark,1. Colorado Tick Fever: Gallatin, 2. Rocky Mtn Spotted Fever: S.Bow,1. Rubella: Deer Lodge,1. Strep pneumococcal meningitis: Meagher,1.

DELAYED REPORTS:
Measles (MAY): Flathead,6. all imported

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Volume: 10: 7 **Month of:** JUNE 1986

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MONTANA STATE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

POSITION PAPER: GIARDIA

Giardia (Giardia lamblia) is a microscopic protozoan that can cause a painful intestinal disorder called giardiasis.

Significant outbreaks of the disease have occurred in several Montana cities. In each instance, a portion or all of the cities' drinking water was obtained from unfiltered surface water and the cases were epidemiologically linked to the drinking water. Although giardiasis is generally not life-threatening, it can be debilitating to certain groups of high-risk persons.

BACKGROUND

Giardia is a one-celled organism that has a two-staged life cycle -- a trophozoite or active stage and a dormant cyst stage. Infection occurs through ingestion of cysts. These cysts are stimulated by acid in the host's stomach to release two trophozoites. Trophozoites colonize the upper small intestine where their population increases through asexual multiplication (binary fission). For unknown reasons, a few to several million trophozoites will periodically release their hold on the lining of the small intestine, form cysts and be excreted as this dormant stage and become ready for ingestion by a new host.

Severe diarrhea, stomach cramps and sulfurous belching are common symptoms, yet in some instances the victim has no idea he or she is infected.

Aquatic animals, such as beavers and muskrats, are often the culprits that contaminate public water supplies, however, there are many other carriers which include coyotes, cattle, dogs, cats and humans.

Unfiltered surface water often is responsible for large numbers of people becoming infected, however person-to-person contact and social practices also spread the disease.

Giardiasis can be treated with prescribed drugs. Pregnant women and those allergic to the drugs should be closely supervised by a physician if medication is necessary. Persons with other health problems, small children, the elderly and immune deficient are at greatest risk. Fatalities directly attributed to giardiasis are rare, but possible, particularly to those high risk individuals.

For some the disease may last for only a couple of weeks, for others it may occur on and off for months or even years, if left untreated.

PREVENTION

Good personal hygiene habits, such as thoroughly washing one's hands, and being cautious in settings where giardiasis cases have been diagnosed, can help prevent contracting the disease.

Another means of prevention is to avoid drinking directly from springs, streams or lakes. Well water is safe from contamination, and usually the best bet if there is a choice. If surface water is the only available source, boiling for five minutes at 10,000 feet above sea level to one minute at sea level will kill the cysts, bacteria and viral contaminants in the water.

Public water systems -- both municipal and private -- have the potential to pass the disease to many people. The best means of prevention is to chemically treat, filter, and chlorinate the water. A properly operated filtration plant can remove more than 99% of the cysts, and also will remove small suspended particles, making chlorination more effective. A poorly designed or operated treatment facility can also provide water of unsafe quality.

A second effective measure is to drill wells and abandon surface water supplies.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES' COURSES OF ACTION

The Department of Health and Environmental Sciences (DHES) will continue to list giardiasis as a disease to be reported by local health officials. Clusters of cases will be investigated and DHES personnel will provide whatever assistance or expertise available to help local health organizations.

As for public water systems, the DHES' ultimate goal is to insure that all public water systems that use surface water are capable of removing or inactivating Giardia cysts.

Until the DHES is assured a system is capable of providing safe water, it will require the persons in charge of unfiltered public systems to issue a health advisory to their users indicating that there is a potential threat to public health. The notification shall include advice on precautionary measures, such as boiling and the use of point-of-use treatment devices. Public establishments, such as motels and restaurants, will be advised to either provide additional treatment or notify their customers that there is a health risk associated with the consumption of untreated water.

If outbreaks of giardiasis are traced to public water supplies, the DHES shall issue a boil order which will remain in effect until the source of the disease has been discovered and eliminated. The order will notify the public that all water for cooking or drinking must be boiled to assure its safety. Public establishments will be advised to provide acceptable treatment or close down until the boil order is lifted.

ASSISTANCE

Persons who would like information about providing filtration and treatment to homes, businesses or public water systems should call the Water Quality Bureau, DHES, 444-2406.

Those who would like more information about the public health risks and treatment of giardiasis should call their local health department or the Communicable Disease Program, DHES, 444-4740.

GET READY FOR INFLUENZA

The Immunization Practices Advisory Committee (ACIP) has published the Prevention and Control of Influenza update for 1986-1987. The whole of the recommendations are contained in the Morbidity and Mortality Weekly Report (MMWR) May 23, 1986.

Now is the time to begin planning for administration of influenza vaccine in advance of the "flu season". There will be a state term contract number local health departments can use to order vaccine at a reduced cost if the quantity is large enough. Smaller health departments may want to order cooperatively to take advantage of the price break for larger orders. More information will be forthcoming in future issues of this publication.

Monovalent Influenza A(H1N1) Vaccine, 1986-1987

These supplemental recommendations provide guidelines for a monovalent influenza A(H1N1) vaccine for protection against a newly emerged variant of influenza that has recently caused outbreaks among children and young adults in Asia. Guidance is provided for the use of this monovalent vaccine, which contains 15 ug of A/Taiwan/1/86(H1N1) antigen, as a supplement to the standard trivalent influenza vaccine. Recommendations for the use of the standard trivalent influenza vaccine for the 1986-1987 season and the use of antivirals for the prevention and treatment of influenza (MMWR 1986;35:317-26, 331) remain in effect and should be referred to in conjunction with this supplemental recommendation.

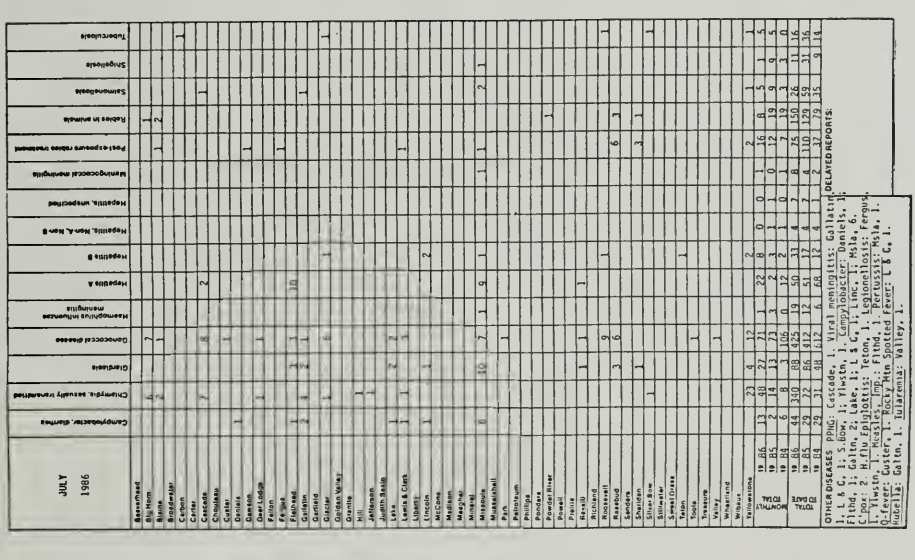
It is not possible to predict how widely these new A(H1N1) variants will circulate in the United States during 1986-1987, nor the actual level of protection that A/Chile/1/83 vaccine will induce against them. However, it seems prudent to maximize protection of individuals at high risk of serious complications following influenza A(H1N1) infection in the event that these newer A(H1N1) viruses do cause major outbreaks in the United States. Vaccine manufacturers have, therefore, been requested to initiate production of a supplemental monovalent A(H1N1) influenza vaccine for use before the 1986-1987 season.

RECOMMENDATION

Individuals under 35 years of age for whom influenza vaccination has been specifically recommended (%) should receive both the standard trivalent vaccine and the monovalent A/Taiwan/1/86 (H1N1) vaccine.

Any high-risk person aged 35 years and older, or any other person who wishes to be immunized, may also receive the supplemental vaccine.

Complete information regarding the administration of the monovalent vaccine are contained in the MMWR 8/15/86. Please contact MDHES at 444-474D with questions and/or concerns.



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MONTANA MORBIDITY REPORT

Volume: 10: 8 Month of: JULY 1986

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RUBELLA VACCINATION ASSOCIATED WITH PREGNANCY

In Montana and elsewhere in the United States, public health agencies have increasingly emphasized rubella vaccination of susceptible women of childbearing age. The purpose of this emphasis is to prevent the occurrence of congenital rubella syndrome (CRS) in offspring of the 14-15% of women of childbearing age who remain susceptible to rubella.

With this emphasis on immunizing women who could potentially become pregnant, concern has been expressed about the theoretical risk to the fetus if a woman is inadvertently immunized during pregnancy. When the currently used RA27/3 rubella vaccine was first introduced in 1979, concern was raised that it might be more likely to cause fetal infection and birth defects than the previously available vaccine.

Since 1971, the Centers for Disease Control (CDC) has maintained a registry to monitor the risks to the fetus following exposure to attenuated rubella vaccine virus. Fortunately, the results continue to be reassuring.[1]

Since the licensure of RA27/3 rubella vaccine in January, 1979, CDC has identified 614 women who received this vaccine during pregnancy. (See Table 1.) Of the 505 infants known to be born to these women, all were free of defects compatible with CRS.

Fifty-three (35%) of the 153 mothers known to be susceptible were vaccinated with RA27/3 vaccine during the highest-risk period for fetal infection and congenital defects (1 week before to 4 weeks after conception). None of their infants were born with CRS.

Of the 155 infants born to mothers who were susceptible at time of vaccination, 121 (78%) were serologically tested after birth. None had clear serologic evidence of intrauterine rubella virus infection. One normal child had equivocal evidence of such infection. (A rubella-specific IgM antibody titer of 1:8 in cord blood was not in agreement with a declining hemagglutination inhibition titer from 1:64 to 1:16 over the two months after delivery.)

Of the 320 infants born to mothers whose immune status was unknown at time of immunization, 156 were serologically tested. Two had serological evidence of intrauterine infection. Both were clinically normal.

While no CRS-like defects have been noted in infants born to mothers vaccinated during pregnancy, it is clear that the rubella vaccine virus can cross the placenta and infect the fetus. In addition to the serologic evidence cited above, rubella virus was isolated from the products of conception from 1 of 34 (3%) women who had abortions after receiving RA27/3 vaccine during pregnancy. This compares to 20% (17 of 85) for the previously available Cendehill and HPV-77 vaccines.

These favorable data are consistent with reports from Germany and the United Kingdom.[2,3]

RECOMMENDATIONS

In view of the data collected through 1985, the Montana Immunization Program continues to recommend that all physicians and health departments strongly encourage women of childbearing age who are not known to be immune to receive rubella vaccine. The Immunization Practices Advisory Committee (ACIP) continues to state, however, that: (1) pregnancy remains a contraindication to rubella vaccination because of the theoretical, albeit small, risk of CRS; (2) reasonable precautions should be taken to preclude vaccination of pregnant women, including asking women if they are pregnant, excluding those who say they are, and explaining the theoretical risks to the others; and (3) if vaccination does occur within 3 months before or after conception, the risk of CRS is so small as to be negligible; thus, rubella vaccination of a pregnant woman should not ordinarily be a reason to consider interruption of pregnancy. The patient and her physician, however, should make the final decision.

Table 1: Pregnancy outcomes for 614 recipients of RA 27/3 vaccine -- United States, January 1979 through December 1985

Prevaccination immunity status	Total women	Live Births	Spontaneous abortions and stillbirths	Induced abortions	Outcome unknown
Susceptible	203	155*	8	30	12
Immune	32	30	1	0	1
Unknown	379	320**	8	24	28
TOTAL	614	505	17	54	41

* Includes two twin births.
**Includes one twin birth.

REFERENCES

(1) Centers for Disease Control: Rubella vaccination during pregnancy -- United States 1971-1985. MMWR 1986;35:275-276, 281-284.

(2) Enders G: Rubella antibody titers in vaccinated and nonvaccinated women and results of vaccination during pregnancy. Rev Infect Dis. 1985;7 (suppl. 1):S103-7.

(3) Tobin J, Sheppard S, Smithells RW, Milton A, Noah N, Reid D: Rubella in the United Kingdom, 1970-1983. Rev Infect Dis. 1985;7 (suppl. 1):S47-S52.

Excerpted from: "Communicable Disease Summary," Oregon Department of Human Resources, Oregon Health Division, Vol. 35, No. 10., May 24, 1986.

AUGUST 1986	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead				1											
Big Horn		6		2											1
Blaine				2											
Broadwater													1		
Carbon															
Carter											2				
Cascade	2	5		9		1	1								
Chouteau															
Custer				2								2			
Daniels															
Dawson															
Deer Lodge															
Fallon											1	2	1		
Fergus			2									1	1		
Flathead		1	1	4	1	3	1				3	1			
Gallatin	1	3	2								1				
Garfield															
Glacier			1	7			1				2				1
Golden Valley															
Granite															
Hill		1		3											
Jefferson				1											
Judith Basin															
Lake		1	6	3		1									
Lewis & Clark		2	2	2			1				2	2	1		
Liberty											1				
Lincoln		2	1			1									
McCone															
Madison															
Meagher															
Mineral															
Missoula	1	4	2	3				1					1		1
Musselshell															
Park															
Petroleum															
Phillips															
Pondera												1			
Powder River															
Powell															
Prairie															
Ravalli				1											
Richland				1											
Roosevelt				5											
Rosebud				2								1			
Sanders															
Sheridan															
Silver Bow		1		2									2		
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley												1		1	
Wheatland															
Wibaux															
Yellowstone	1	25	3	13			1		1		1		1		
MONTHLY TOTAL 1986	5	51	20	63	1	6	5	1	1	0	13	11	8	1	3
MONTHLY TOTAL 1985	7		11		0	4	4	0	2	0	4	9	11	15	5
MONTHLY TOTAL 1984	11		18		1	30	6	0	0	0	13	12	5	1	6
TOTAL TO DATE 1986	49	391	108		20	56	38	5	8	8	88	161	34	12	19
TOTAL TO DATE 1985	36	76	96		12	51	17	4	9	4	114	138	70	46	41
TOTAL TO DATE 1984	40	35	66		7	68	12	4	1	2	50	91	40	10	20

OTHER DISEASES: Colorado Tick Fever: Silver Bow 2, Beaverhead 1; TSS: Silver Bow 1; Amebiasis: Lincoln 1, Fergus 1, Rocky Mt. Spotted Fever: Yellowstone 1; Pertussis: Hill 1, Fergus 1; Flathead 3; Legionellosis: Yellowstone 1; Measles: Gallatin (imported) 1

DELAYED REPORTS: Brucellosis: Madison 1 (June)

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MONTANA MORBIDITY REPORT

Volume: 10: 9 Month of: AUGUST 1986

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MEDICAL DEVICES MONITORING DURING MANUFACTURE AND USE

The 1976 Medical Device Amendments to the Federal Food, Drug and Cosmetic Act provided the Food and Drug Administration (FDA) with significant new authority to assure the safety and effectiveness of devices intended for human use. Within the three (3) classifications of devices one will find products ranging from clinical thermometers to x-ray machines to prosthetic implants. The definition of a medical device is "a health care product that does not achieve any of its intendeo purposes by chemical action within or on the body by being metabolized." If the product has chemical action it is considered a drug.

The Medical Device Reporting Regulation outlines the scope of the law. "A device manufacturer or importer is to report to FDA whenever they receive or otherwise become aware of information that reasonably suggests one of its marketed devices has caused or could cause death and/or serious injury."

Manufacturers, importers and the FDA rely on individuals, institutions, e.g., physicians, nurses, patients, consumers and hospitals to learn of medical device malfunctions.

Reports nf death or serious injury due to medical device malfunction should be made immediately by telephone. Malfunctions of devices which could cause death or serious injury can be made in writing as soon as the necessary information is gathered.

If you wish to report a malfunction of a medical device, collect the following information:

(1) device identification such as brand name, serial number, model number, etc.

(2) manufacturer or importer of the device,

(3) identify yourself, name, address, phone,

(4) describe the event you want to report in full detail.

A report can be made directly to FDA at the following address:

Device Monitoring Branch (HF2-343)
Centers for Devices and Radiological Health
Food and Drug Administration
8757 Georgia Avenue
Silver Spring, Maryland
Telephone Number (301) 427-7500

If you have any questions or don't desire reporting directly to FDA, reports of medical device malfunction can be made to Judith Cedrose, R.N., M.N., State Epidemiologist at 444-4740.

TUBERCULOSIS TREATMENT GUIDELINES UPDATED

The American Thoracic Society - Centers for Disease Control have published updated recommendations for treatment of tuberculosis and tuberculosis infection in adults and children effective March 1986. They are summarized below.

SUMMARY

Treatment of Tuberculosis:

1. A 6-month regimen consisting of isoniazid, rifampin, and pyrazinamide given for two months followed by isoniazid and rifampin for four months is effective treatment in patients with fully susceptible organisms who comply with the treatment regimen. It may be advisable to include ethambutol in the initial phase when isoniazid resistance is suspected.

2. A 9-month regimen consisting of isoniazid and rifampin is also highly successful. The need for an additional drug in the initial phase is not certain unless isoniazid resistance is suspected, in which case ethambutol should be included until susceptibility tests have been reported.

3. In the presence of documented resistance to isoniazid, rifampin and ethambutol, perhaps supplemented initially by pyrazinamide, should be given for a minimum of 12 months.

4. Children should be treated in essentially the same ways as adults using appropriately adjusted doses of the drugs. However, consideration must be given to the important differences in the approach to management in children.

5. Extrapulmonary tuberculosis should be managed according to the principles and with the drug regimens outlined for pulmonary tuberculosis.

6. The major determinant of the outcome of treatment is patient compliance. Careful attention should be paid to measures designed to foster compliance and to ensure that patients take the drugs as prescribed.

Treatment of tuberulous infection:

1. Preventive therapy with isoniazid given for 6 to 12 months is effective in decreasing the risk of future tuberculosis.

2. Persons for whom preventive therapy is indicated include: household members and other close contacts of potentially infectious persons; newly infected persons; persons with past tuberculosis or with a significant tuberrculin reaction and abnormal chest films in whom current tuberculosis has been excluded; infected persons in special clinical situations such as silicosis, diabetes mellitus, adrenocorticosteroid therapy, immunosuppressive therapy or diseases, AIDS or positive tests for antibodies to AIDS virus, hematologic and reticuloendothelial malignancies, end-stage renal disease, and clinical conditions associated with rapid weight loss or chronic undernutrition; tuberculin skin test reactors younger than 35 years of age.

3. In persons younger than 35 years of age, routine monitoring for adverse effects of isoniazid should consist of a monthly symptom review. For persons 35 and older, in addition to monthly symptom reviews, hepatic enzymes should be measured prior to starting isoniazid and periodically throughout treatment.

4. Persons at high risk of developing severe forms of tuberculosis, if infected due to contact with a patient having isoniazid-resistant organisms, should be treated with rifampin rather than isoniazid. Lower-risk contacts can be treated with isoniazid and observed carefully.

5. As with treatment of tuberculosis, the key to success of preventive therapy is patient compliance.

AM REV RESPIR DIS 1986; 134:355-363

JC/vg-0117a

SEPTEMBER 1986	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		3		4											
Blaine				3											
Broadwater		1													
Carbon							1								
Carter							1					2			
Cascade		4		7		1					2				
Chouteau															
Custer															
Daniels												1			
Dawson															
Deer Lodge			1										1		
Fallon												1			
Fergus			5												
Flathead	1		4	2		2									2
Gallatin	2		5								2	1			
Garfield												1			
Glacier				9		1									
Golden Valley															
Granite															
Hill		1		1											
Jefferson															
Judith Basin			12												
Lake				4		2							2		
Lewis & Clark		4	1	6							1				
Liberty															
Lincoln													1		
McCone															
Madison	1														
Meagher															
Mineral				2											
Missoula		2	11	5									2		
Musselshell													1		
Park															
Petroleum															
Phillips															
Pondera			2												
Powder River															
Powell															
Prairie			1								1	1			
Ravalli				1			1								
Richland															
Roosevelt		1		7		1					1		1		2
Rosebud				2							1	1			
Sanders															
Sheridan											1				
Silver Bow		1		1									1		
Stillwater															
Sweet Grass															
Teton				1											
Toole															
Treasure															
Valley													1		
Wheatland															
Wibaux															
Yellowstone		21	1	5				1					1		
MONTHLY TOTAL 1986	4	42	43	60	0	7	3	1	0	0	9	8	11	0	4
MONTHLY TOTAL 1985	5	12	25	72	6	19	17	3	2	1	9	25	9	3	0
MONTHLY TOTAL 1984	2	12	13	81	0	15	2	0	1	0	15	9	11	2	3
TOTAL TO DATE 1986	53	432	434	548	20	63	41	6	8	8	97	169	45	12	23
TOTAL TO DATE 1985	42	88	131	557	18	70	34	7	11	5	123	163	79	49	41
TOTAL TO DATE 1984	42	47	79	790	7	83	14	4	2	2	65	100	51	12	23

OTHER DISEASES: Aseptic Meningitis: Yellowstone, 1; Enceph.,Prim.: Lincoln, 1; Pertussis: Hill, 1; Toxic Shock: Pondera, 1; Amebiasis: Glacier, 1; Chickenpox: Lake, 3

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Volume: 10:10 Month of: SEPTEMBER 1986

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MONTANA STATE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MICROBIOLOGY LABORATORY BUREAU 444-2642

LIST OF SERVICES

The following is a list of services routinely performed at the State Microbiology Laboratory in Helena. If you have any questions about specific tests that we run besides the routine cultures, give us a call. Also feel free to call us with questions regarding specimen collection, handling, or mailing.

Clinical Microbiology

Reference Bacteriology for specimens which are:

1) from an outbreak
2) from an uncommon or exotic disease
3) isolates that cannot be identified, are atypical, show multiple antibiotic resistance, or from normally sterile sites
4) from a disease for which reliable diagnostic reagents or expertise are not available
5) confirmation of results requested for quality assurance

Routine primary culturing and/or identification of isolates for:

Mycobacterium sp. (including sensitivity testing of isolates)
Salmonella/Shigella screens
Campylobacter
Beta-hemolytic Streptococcus screens
Neisseria gonorrhoeae screens
Chlamydia -- Direct Exam: specimens on supplied slides
-- Isolation: conjunctival swab, genital swab into special Chlamydia transport medium
Bordetella sp.
fungi
Legionella sp.

Miscellaneous testing:

Clostridium difficile toxin
Serotyping and serogrouping of organisms as appropriate
Direct Flourescent Antibody testing for Bordetella sp., Legionella sp., and others

Parasite identification (stool in formalin and/or PVA)

Fungal serology tests (performed at COC in Atlanta)

Parasite serology tests (performed at CDC)

Clinical Chemistry

Neonatal blood tests:

PKU
Galactosemia
T-4
TSH

Coliform analysis of public and private drinking water supplies.

Virology and Serology

Disease or Agent	Serology	Isolation Specimens[1]
CNS		
Aseptic meningitis	A,C[2]	Stool, throat, CSF
Meningo-Encephalitis	A,C	Stool, throat, CSF
Paralytic disease	A,C	Stool, throat
Guillian-Barre	A,C	Stool, throat, CSF
Arbovirus	A,C	Stool, throat
Respiratory		
Influenza	A,C	Throat
Adeno	A,C	Stool, throat
Acute Resp. Infection	A,C	Throat
Croup-Laryngo Tracheo bronchitis	A,C	Throat
Pleurodynia	A,C	Stool, throat
Mycoplasma pneumonia	A,C	
Psittacosis/Q Fever	A,C	
Exanthems		
Rubella	A,C	
Rubeola	A,C	Throat, urine, clotted blood
Coxsackie/Echo		Throat, stool
Herpes simplex	A,C	Vesicle fluid/swab
Varicella-Zoster	A,C	Vesicle fluid/swab
Rickettsial/Colorado tick fever virus	A,C - C as early as one week	
Miscellaneous		
Hepatitis	A	
Mumps	A,C	Saliva
Myocarditis		Throat, stool
Pericarditis		Throat, stool
Epidemic Kerato conjunctivitis	A,C	Stool, conjunctival wash or scrapings
Ocular Herpes	A,C	Conjunctival wash/scrapings
Infantile diarrhea	A,C	Stool
Cytomegalovirus	A,C	Urine, throat, heparinized blood
Lymphogranuloma	A,C	
HTLV III	A	
Rubella Screens		
Syphilis		
Brucellosis	A,C	
Tularemia	A,C	
Nennatal Hepatitis/TORCH		Mother's and baby's serum or cord blood at birth; baby's again at 3 months.

1) Transport medium supplied by request
2) A-Acute, C-convalescent

OCTOBER 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		5		3											
Blaine		1										2		3	
Broadwater			1							1					
Carbon															
Carter															
Cascade		17		10		1		1						1	
Chouteau															
Custer				1							1				
Daniels											1	1			
Dawson					1								1		
Deer Lodge		1	3										2		
Fallon															
Fergus			2									1			
Flathead				2		1									
Gallatin	1	14	7		1										
Garfield															
Glacier				7			1								
Golden Valley															
Granite															
Hill		4		2							1				
Jefferson															
Judith Basin															
Lake			5	4		2	2								
Lewis & Clark		9	2	4		2	1						2		
Liberty															
Lincoln	1	1	2												
McCone												1			
Madison															
Meagher															
Mineral			1												
Missoula	1	6	6	5			1	1			1		2		
Musselshell				1											
Park													1		
Petroleum															
Phillips															
Pondera															
Powder River												1			
Powell															
Prairie															
Ravalli	1					2									
Richland															
Roosevelt			1	1		1									
Rosebud				3							2	1			2
Sanders								1							
Sheridan												1			
Silver Bow		2		2						1	1		1		
Stillwater															
Sweet Grass															
Teton															
Toole												1			
Treasure															
Valley											1	1			
Wheatland															
Wibaux												2			
Yellowstone		29	4	5			1		1						
MONTHLY TOTAL 1986	4	89	34	50	2	9	5	3	1	2	7	12	9	1	2
MONTHLY TOTAL 1985	4	14	32	96	6	12	8	0	1	1	8	41	5	7	5
MONTHLY TOTAL 1984	8	4	33	75	1	13	4	1	3	0	4	7	7	1	0
TOTAL TO DATE 1986	57	521	468	598	22	72	47	9	9	10	109	181	44	15	25
TOTAL TO DATE 1985	46	102	153	652	24	86	46	7	5	5	131	204	24	57	46
TOTAL TO DATE 1984	50	51	112	865	8	126	24	5	2	2	69	807	58	13	22

OTHER DISEASES: Aseptic Meningitis: Valley, 1; Pertussis: Hill, 1: Yellowstone, 1; Chickenpox: Gallatin, 1: Hill, 6; Lake, 16: Wheatland, 2; Bacterial Meningitis Unspec: Silver Bow, 2

DELAYED REPORTS: Post-exposure Rabies:Flathead, 1 (August): Yellowstone, 1 (August): Yellowstone, 2 (September)

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New Recommended Schedule for Active Immunization of Normal Infants and Children

Until now, the recommended schedule for active immunization of normal infants and children called for administering combined measles-mumps-rubella (MMR) vaccine at 15 months and giving the fourth dose of Diphtheria and Tetanus Toxoids and Pertussis Vaccine (DTP) and the third dose of oral poliovirus vaccine (OPV) at 18 months (*1*). Two visits have been needed to receive these vaccines in the second year of life because the safety and efficacy of administering all three simultaneously had not been proven.* A large, randomized, double-blind trial has recently been completed (*2*), and sufficient data are now available to recommend the simultaneous administration of MMR, DTP, and OPV to all children 15 months old or older who are eligible to receive these vaccines (Table 1).

In this trial, serologic response and clinical reaction rates following primary immunization with MMR were compared in a test group of 405 children given MMR simultaneously with DTP and OPV and a control group of 410 children given MMR followed by doses of DTP and OPV vaccine 2 months later. Seroconversion rates to each MMR component exceeded 96% in both groups, and the geometric mean titers achieved against the other six antigens were also similar in both groups. Rates of most of the common vaccine-associated clinical reactions to DTP and MMR were not augmented by simultaneous administration of these two vaccines. Some minor side effects were reported more frequently in the simultaneous-administration group; however, these differences were judged to be related to artifacts of the study design rather than to differences in the safety of the two vaccine schedules.

Data from CDC's Monitoring System for Adverse Events Following Immunization (MSAEFI) have been reviewed, particularly the information from Idaho, Louisiana, and Tennessee, where policies to administer MMR, DTP, and OPV simultaneously have been in effect for periods ranging from several months to years. Although there are limitations to the use of the MSAEFI data set for this purpose, the evidence suggests no increased risk of reactions associated with the simultaneous administration of these antigens.

*It should be noted that simultaneous administration of MMR, DTP, and OPV was previously recommended for children who were behind schedule in receiving their immunizations. This recommendation was based on the demonstrated safety and efficacy of other vaccine combinations (e.g., DTP and measles, or MMR and OPV).

Although the overall implications of simultaneous administration have not been fully defined, it is anticipated that implementation of this new schedule will result in at least three benefits: (1) a decrease in the number of health-care provider visits required for immunization during the second year of life, (2) an accompanying decrease in costs, and (3) an increase in the percentage of children who will be fully or partially immunized by 24 months of age.

Some health-care providers may continue to prefer administering MMR at 15 months followed by DTP and OPV at 18 months, especially for patients who are known to be compliant with health-care recommendations or if other purposes are served by the additional visit. Such a schedule remains an acceptable alternative to the newly proposed schedule involving simultaneous administration of DTP, MMR, and OPV in a single visit.

References

1. ACIP. General recommendations on immunization. MMWR 1983;32:1-17.
2. Deforest A, Long FF, Lischner HW, et al. Simultaneous administration of measles-mumps-rubella (MMR) with booster doses of diphtheria-tetanus-pertussis (DTP) and poliovirus (OPV) vaccines (unpublished data).

TABLE 1. New recommended schedule for active immunization of normal infants and children*

Recommended age†	Vaccine(s)§	Comments
2 months	DTP-1¶, OPV-1**	Can be given earlier in areas of high endemicity
4 months	DTP-2, OPV-2	6-week to 2-month interval desired between OPV doses to avoid interference
6 months	DTP-3	An additional dose of OPV at this time is optional for use in areas with a high risk of polio exposure
15 months††	MMR,§§ DTP-4, OPV-3	Completion of primary series of DTP and OPV
24 months	HbPV¶¶	Can be given at 18-23 months for children in groups who are thought to be at increased risk of disease, e.g., day-care-center attendees
4-6 years***	DTP-5, OPV-4	Preferably at or before school entry
14-16 years	Td†††	Repeat every 10 years throughout life

*See Reference 1 for the recommended immunization schedules for infants and children up to their seventh birthday not immunized at the recommended time in early infancy and for persons 7 years of age or older.

†These recommended ages should not be construed as absolute, i.e., 2 months can be 6-10 weeks, etc.

§For all products used, consult manufacturer's package enclosure for instructions for storage, handling, and administration. Immunobiologics prepared by different manufacturers may vary, and those of the same manufacturer may change from time to time. The package insert should be followed for a specific product.

¶DTP-Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed.

**OPV-Poliovirus Vaccine Live Oral; contains poliovirus strains Types 1, 2, and 3.

††Provided at least 6 months have elapsed since DTP 3 or, if fewer than three DTPs have been received, at least 6 weeks since last previous dose of DTP or OPV. MMR vaccine should not be delayed just to allow simultaneous administration with DTP and OPV. Administering MMR at 15 months and DTP-4 and OPV-3 at 18 months continues to be an acceptable alternative.

§§MMR-Measles, Mumps, and Rubella Virus Vaccine, Live.

¶¶Hemophilus b Polysaccharide Vaccine.

***Up to the seventh birthday.

†††Td-Tetanus and Diphtheria Toxoids Adsorbed (For adult use)—contains the same dose of tetanus toxoid as DTP or DT and a reduced dose of diphtheria toxoid.

Out-of-Hospital Care Givers/Health officers interact in CD Control

Out-of-hospital health care personnel and associates have voiced concerns about being exposed to reportable diseases and not knowing about such an exposure. Emergency medical personnel may not have a continuing relationship with a patient who at the time of their contact has a communicable disease. Because the communicable disease is not diagnosed until after the emergency personnel contact with the patient, the emergency personnel may need to be informed retrospectively. Out-of-hospital care providers such as home health personnel and persons coming in contact with the bodies of persons dead of communicable disease have the same concerns and in some instances do need to know of contact with a case.

The employment of suggested infection control practices at all times will essentially eliminate transmission of any of the reportable diseases of concern. Handwashing immediately after contact with patients is always warranted. Avoid being sprayed by the cough of a patient. This can be accomplished with barriers such as a tissue over the patient's mouth or wearing of a mask. Body fluid and blood precautions are indicated if soiling of clothing or hands with blood or body fluids is anticipated. Hands must be washed as soon as possible after contact even if gloves are worn. Articles contaminated with blood or body fluid should not be handled unless gloves are worn. Accidents such as needle- stick injuries, inadvertent puncture wounds with sharp instruments and/or spraying of body fluids can be prevented. If contamination does occur immediate flushing of the contaminated body site of the worker with running water is indicated. Precutaneous punctures warrant evaluation by a physician as to the need for prophylaxis and/or follow-up. Blood spills or other body fluid spills such as vomitus can be disinfected with application of 5.25% diluted 1:10 with water or other EPA-approved germicide. Then the fluids are lifted with disposable toweling by a person with gloved hands.

If a reportable disease occurs, the local health officer is responsible for "whatever steps deemed appropriate and necessary for the investigation and control of the disease occurring within his jurisdiction." This includes identifying contacts who may be at risk of infection. The rule goes on to say, "If he finds that the nature of the disease and the circumstances of the case . . . warrant such action, he shall make . . . an epidemiological investigation to determine the source and possible spread of infection and take appropriate steps to prevent or control the spread of disease." The State Health Department is available on the request of local health officers to assist them with this process (Administrative Rules of Montana 16.28.403). Consideration for clarifying this rule is being made when the entire communicable disease Administrative Rule chapters is redone within the next six months. Mention will be made of the need to consider out-of-hospital care givers and body attendants in the identification of contacts.

Emergency medical personnel and other out-of-hospital care givers should have a continuing relationship with their local health officer regarding the mechanisms for notification of contacts of reportable diseases. Not all reportable diseases or the circumstances surrounding a particular disease warrant notification of contacts but if such an occasion does arise it will occur in a more timely manner if the health officer knows how to contact the persons involved.

Polio Vaccine for International Travel

The October 31, 1986 Morbidity and Mortality Weekly Report (MMWR) includes an article entitled, "Imported Paralytic Poliomyelitis -- United States 1986." "From 1980 through 1985 the only four cases of wild virus paralytic poliomyelitis occurring in US citizens was acquired outside the U.S." Therefore the recommendation for consideration of polio immune status for international travelers appears to be strengthened. Visitors to any area of the world other than the United States, Canada, Japan, Australia, New Zealand and most of Eastern and Western Europe should be given an "additional dose" of polio virus if they have completed a primary series of polio vaccine in the past. This additional dose is to be given only one time. A primary series is indicated for those who haven't completed one. For more complete recommendations one should consult MMWR, Vol. 35, No. 43 or the following references:

(1) ACIP. Poliomyelitis Prevention. MMWR 1982; 31:22-6, 31-4.
(2) ACIP. Adult Immunization. MMWR 1984; 33:75-68S.
(3) Committee on Immunization, American College of Physicians, Guide for Adult Immunization. Philadelphia, PA. American College of Physicians, 198S.
(4) CDC. Health Information for International Travel, 1986. Atlanta, GA. U.S. Department of Health and Human Services, Public Health Service, 1986. HHS Publication No. (CDC) 86-8280.

Important information forms are available for the following vaccines:

Monovalent Influenza
Hepatitis B
Influenza
Pneumococcal Polysaccharide
Haemophilus B Polysaccharide
Measles, Mumps and Rubella
Polio and Oral Polio
Diphtheria, Tetanus and Pertussis

If you would like a supply of these forms, please contact the Montana Immunization Program at 444-4740.

JG/war-041b

MONTANA MORBIDITY REPORT

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Volume: 10:12 **Month of:** November 1986

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620.
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NOVEMBER 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead													1		
Big Horn		2	1	1											
Blaine			1											6	
Broadwater															
Carbon															
Carter												1			
Cascade		12	1	4											
Chouteau												1			
Custer												1			
Daniels															
Dawson	1														
Deer Lodge													1	1	
Fallon															
Fergus												1			
Flathead	1	13	1	3	2						2				
Gallatin			1	4							1				
Garfield															
Glacier			2												
Golden Valley															
Granite															
Hill		5	1												
Jefferson															
Judith Basin															
Lake			7	2		1									
Lewis & Clark		2	1	2				1					3		
Liberty															
Lincoln		1		1											
McCone															
Madison															
Meagher															
Mineral															
Missoula	2	8	4	9	1		1								
Musselshell															
Park															
Petroleum															
Phillips															
Pondera															
Powder River											1	1			
Powell															
Prairie															
Ravalli			2												
Richland															
Roosevelt				6		2							1		
Rosebud				1								1			
Sanders												1			
Sheridan												2			
Silver Bow		1							1		1				
Stillwater															
Sweet Grass															
Teton				1											
Toole												1			
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		24	2	7			1						1		
MONTHLY TOTAL 1986	4	68	24	41	3	3	2	1	1	0	5	10	7	7	0
MONTHLY TOTAL 1985	3	6	11	77	5	9	3	0	1	0	29	24	3	0	0
MONTHLY TOTAL 1984	2	10	17	69	1	26	1	1	0	0	3	13	1	0	6
TOTAL TO DATE 1986	61	589	492	639	25	75	49	10	10	10	114	191	51	23	27
TOTAL TO DATE 1985	49	108	164	729	29	95	49	7	7	6	160	228	37	52	46
TOTAL TO DATE 1984	52	61	129	934	9	152	25	6	2	2	71	120	59	13	28

OTHER DISEASES: Malaria: Flathead, 1; Mumps: Yellowstone, 1; Pertussis: Hill, 1: Missoula, 4; Aseptic Meningitis: Beaverhead, 1; Chickenpox: Gallatin, 1: Lake, 24; Q-Fever: Custer, 1; Kawasaki Syndrome: Flathead, 1; Legionellosis: Chouteau, 1

DELAYED REPORTS: TUBERCULOSIS

CORRECTIONS: June: delete 1 from Fergus; July: delete 1 from Silver Bow; Sept.: Add 1 to each Roosevelt, Missoula, Silver Bow & Yellowstone: Oct.: delete 2 from Rosebud, add 2 to Roosevelt

Montana AIDS Project

The Montana AIDS Project has designated eight (8) agencies in Montana to serve as alternate testing sites for HIV antibody reactivity. Through the grant funds provided to these sites, the AIDS Project offers free and confidential pre-test counseling, HIV antibody testing, and post-test counseling for clients and their spouse/spouse equivalent.

If you wish to use these services, contact the Montana AIDS Project (444-4740).

Escherichia coli (E. coli) O157:H7 Associated Illness

by Anne Weber

E. coli serotype O157:H7 has been associated with hemorrhagic colitis/hemolytic uremic syndrome (HUS) in the western United States. We continue to be interested in monitoring for the presence of this disease in Montana. The illness is characterized by hemorrhagic colitis resulting in bloody stools in at least 90% of cases, followed by progression to HUS in about 15-20% of cases. Isolation of the organism from stool is required for diagnosis; since a special selective medium is used to detect this serotype, the DHES Microbiology Laboratory requests that a raw stool be submitted for culture. The optimal isolation of E. coli O157:H7 is achieved within 3 days after onset of the disease; 10 days after onset the organism is no longer shed in the stool.

Questions regarding isolation of E coli O157:H7 may be directed to Anne Weber at the DHES Microbiology Laboratory (444-2642).

New National Bacterial Meningitis and Bacteremia Case Report and Tetanus Surveillance Case Report

MDHES submits comprehensive case reports to Centers for Disease Control for some diseases. Bacterial meningitis is one entity for which we have submitted detailed data. The form was revised 10/86 and therefore we request you discard any blank DHHS bacterial meningitis forms dated prior to 10/86. In the lower left hand corner of the new form you will find CDC 52.15A REV 10-86. Please use forms with this number from now on when reporting a case of bacterial meningitis.

This particular form can now be used for follow-up of the more common bacteremias as well as bacterial meningitis. Haemophilus influenzae invasive disease other than meningitis is also reportable on this form. If cases of bacteremias or HIB invasive disease do occur we would pass the information onto CDC if you submit the forms, although neither are officially reportable in Montana.

There is also a revision in the Tetanus Surveillance Case Report. The new report form is CDC 71.1S Rev 9-86. Please toss old forms into the garbage.

The comprehensive case reports or "long forms" are useful tools for follow-up of specific cases. MDHES encourages local health departments and private practitioners to use the forms in a working manner rather than just copying the data onto the form after the fact. Please contact the Field Health Officer (FHO) for your geographic area with requests for long forms and other assistance. Field Health Officers for the various counties are as follows:

Bruce Desonia (Missoula) -- 721-5700, ext. 384

Counties Served
Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, Powell, Granite, Deer Lodge, Ravalli, Silver Bow, Beaverhead, Madison

Stephen Linder (Billings) -- 252-5697

Counties Served
Daniels, Sheridan, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Treasure, Rosebud, Custer, Fallon, Carter, Powder River, Musselshell, Yellowstone, Big Horn, Golden Valley, Stillwater, Carbon, Sweet Grass

Albert Niccolucci (Helena) 444-3629

Counties Served
Glacier, Toole, Liberty, Hill, Blaine, Phillips, Valley, Pondera, Chouteau, Lewis and Clark, Cascade, Judith Basin, Fergus, Petroleum, Jefferson, Broadwater, Meagher, Wheatland, Gallatin, Park, Teton

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Volume: 10:13 **Month of:** DECEMBER

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DECEMBER 1986	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		6										2			
Blaine				3								2			
Broadwater															
Carbon															
Carter															
Cascade		8		7		1									1
Chouteau															
Custer													1		
Daniels															
Dawson												1			1
Deer Lodge															
Fallon															
Fergus			1			1					2	3			
Flathead		3		2							1				
Gallatin		14	2	2											
Garfield															
Glacier			1	2											
Golden Valley															
Granite															
Hill		5	3	6											
Jefferson															
Judith Basin															
Lake			1	1											
Lewis & Clark		11	1	1		1				1	1				
Liberty															
Lincoln			3												
McCone												2			
Madison															
Meagher															
Mineral															
Missoula		6		2			1								
Musselshell															
Park															
Petroleum															
Phillips												1			
Pondera															
Powder River											1	1			
Powell															
Prairie															
Ravalli				2			1								
Richland															
Roosevelt			1	8		1								2	
Rosebud		1		6										1	5
Sanders															
Sheridan															
Silver Bow		2		4											
Stillwater															
Sweet Grass															
Teton															
Toole												2			
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		17	2	6				1							
MONTHLY TOTAL 19 86	0	73	15	52	0	4	2	1	0	1	5	16	1	3	7
MONTHLY TOTAL 19 85	1	10	7	61	3	18	1	0	1	1	5	20	2	0	3
MONTHLY TOTAL 19 84	0	15	9	101	1	3	2	1	1	0	5	5	3	2	4
TOTAL TO DATE 19 86	61	662	507	691	25	79	51	11	10	11	119	207	52	26	34
TOTAL TO DATE 19 85	50	118	171	790	32	114	51	7	8	7	165	248	89	52	49
TOTAL TO DATE 19 84	52	76	138	1035	10	155	27	7	3	2	76	125	62	15	32

OTHER DISEASES: Toxic Shock: Yellowstone, 1; Chickenpox: Lewis & Clark, 14: Lake, 80: Yellowstone, 2; Early latent Syphilis: Rosebud, 2 (under 1 year of age).

DELAYED REPORTS: October: delete 1 case meningococcal meningitis from Silver Bow, add 1 to Granite. November: delete 13 cases chlamydia from Flathead, add 13 to Gallatin.

1986 ANNUAL DISEASE SUMMARY

AIDS - 4
Cascade, 1
Gallatin, 1
Missoula, 1
Yellowstone, 1

Amebiasis - 5
Fergus, 1
Gallatin, 1
Lincoln, 1
Missoula, 2

Botulism - 0

Brucellosis - 1
Madison, 1

Chickenpox - 445
Blaine, 5
Cascade, 2
Daniels, 35
Dawson, 141
Fergus, 3
Flathead, 22
Gallatin, 20
Hill, 6
Lake, 138
Lewis & Clark, 14
Missoula, 17
Roosevelt, 1
Wheatland, 2
Yellowstone, 37

Colorado Tick Fever - 10
Beaverhead, 2
Gallatin, 2
Missoula, 2
Silver Bow, 4

Conjunctivitis - 38

Diphtheria - 0

Encephalitis, post - 1
Lincoln, 1

Herpes, genital - 173
Beaverhead, 1
Big Horn, 2
Cascade, 4 (+ 1 military)
Custer, 1
Dawson, 2
Flathead, 36
Gallatin, 18
Glacier, 3
Hell, 26
Jefferson, 1
Lake, 6

Herpes, genital, cont'd.
Lewis & Clark, 42
Lincoln, 2
Missoula, 2
Park, 6
Ravalli, 1
Roosevelt, 6
Rosebud, 1
Silver Bow, 7
Yellowstone, 5

H-Flu Epiglottis - 2
Flathead, 1
Teton, 1

Influenza - 142

Kawasaki - 1
Flathead, 1

Legionellosis - 3
Chouteau, 1
Fergus, 1
Yellowstone, 1

Malaria - 1
Flathead, 1

Measles, Imported - 9
Broadwater, 1
Flathead, 7
Gallatin, 1

Meningitis, Aseptic - 10
Beaverhead, 1
Cascade, 1
Gallatin, 1
Lewis & Clark, 2
Silver Bow, 1
Valley, 1
Yellowstone, 3

Meningitis, Bacterial Unspecified - 8
Carbon, 1
Lewis & Clark, 1
Lincoln, 1
Silver Bow, 2
Yellowstone, 3

Meningitis, Strep Pneumococcal - 4
Kalispell, 1
Big Horn, 1
Missoula, 1
Meagher, 1

Mononucleosis, infectious - 158

Mumps - 6
Lake, 3
Yellowstone, 3

Ornithosis - 1
Lewis & Clark, 1

Pertussis - 23
Custer, 1
Fergus, 1
Flathead, 5
Hill, 4
Jefferson, 1
Missoula, 6
Valley, 1
Yellowstone, 4

Q-Fever - 2
Custer, 2

Rocky Mtn. Spotted Fever - 4
Lewis & Clark 1
Missoula, 1
Ravalli, 1
Yellowstone, 1

Rubella - 2
Deer Lodge, 1
Gallatin, 1

Strep Throat & Scarlet Fever
2191 cases statewide

Syphilis - 14
Cascade, 1 primary
Glacier, 1 primary
Hill, 1 primary, 1 secondary, 2 early latent >1 year
Roosevelt, 1 primary
Rosebud, 1 primary, 2 early latent >1 year
Silver Bow, 1 early latent >1yr.
Yellowstone, 1 primary, 2 late latent

Toxic Shock - 6
Flathead, 1
Lewis & Clark, 1
Pondera, 1
Silver Bow, 2
Yellowstone, 1

Tularemia - 1
Valley, 1

Typhoid - 1
Flathead, 1

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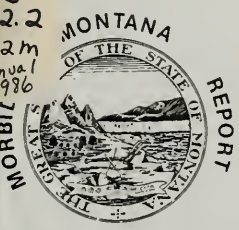

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Annual Summary '86

Volume: Month of:

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Beaverhead			1	5							2		1		
Big Horn		30	3	32		1	1				1	3			
Blaine		8	2	12					1		1	6		9	
Broadwater		1	1							1			1		
Carbon				3			1								1
Carter											1	12			
Cascade	7	70	4	86	1	20	6	1			5	1	1	1	2
Chouteau												2	1		
Custer		1		9							21	15	1		
Daniels	1										2	3			
Dawson	2	2		1	1					1	4	12	2		1
Deer Lodge	1	3	4	1									4	1	
Fallon											5	11			
Fergus			10								4	22	1	2	1
Flathead	6	6	11	29	4	17	2		1	1	7		2		2
Gallatin	12	119	34	27	3	1	3				7	1	3		
Garfield												4			
Glacier	1	2	9	58	1		4				2				2
Golden Valley															
Granite			1	2							1				
Hill		60	6	22	2	1	1				5		1		
Jefferson		2		1											
Judith Basin												1			
Lake	1	4	40	26	4	6	5					1	3		
Lewis & Clark	2	39	11	36		5	2	2		2	9	1	8		1
Liberty					1				1		1		1		
Lincoln	2	4	8	4		2	3						1		
McCone											1	11			
Madison	1										1				
Meagher															
Mineral			2	5											
Missoula	17	59	37	50	3	13	5	2	1	2	4		11	1	4
Musselshell				2								2	1		
Park	1			5									1		
Petroleum															
Phillips		3										5			
Pondera	1		3								1	9	1		
Powder River											3	12			
Powell		1	1	4											
Prairie									1		1	4			
Ravalli	1		5	6	1	4	2								
Richland				1						1		6			
Roosevelt		1	7	72	2	12	1				1	9	7	8	6
Rosebud		1	3	34	2						11	10		1	6
Sanders				1		1		1				1			
Sheridan			1	2							4	12			
Silver Bow	1	18	2	12			1		1	2	5		4		4
Stillwater	1			2			1						1		
Sweet Grass				3											
Teton				2			1								
Toole				2								9			
Treasure															
Valley				3							1	8	1	2	1
Wheatland													1		
Wibaux												12			
Yellowstone	3	232	19	131	3	1	11	5	3	1	8		5	1	3
MONTHLY TOTAL 1986	63	666	229	691*	28	84	51	11	9	11	119	205	65	27	34
1985	53	150	174	794*	28	119	61	5	15	11	170	256	89	53	50
1984	52	75	148	1040*	10	160	26	8	3	2	74	125	61	15	32

*Gonococcal disease totals:
1986 includes 25 military
1985 includes 14 military
1984 includes 14 military

NOTE: TOTALS ARE FROM THOSE COUNTIES REPORTING.